



200 Oceangate Long Beach, CA 90802
 (800) 526-8196 • Fax: (800) 811 4804

SAMPLE

Tracking#: _____
 Please include Tracking number on claim.
 Expiration Date: _____

SERVICE REQUEST FORM

PRODUCT: **MEDI-CAL** **HEALTHY FAMILIES** **AIM** **MEDICARE**

Service is: **NON-URGENT** **URGENT ABUSE OF URGENT PA STATUS WILL BE MONITORED.** Urgent request MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. MHC reserves judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.

Date: 5 125 109

Member Name (Last, First, Middle Initial) Garcia, Andy L. Date of Birth 1 / 2 / 60 Mem I.D. (Social Security Number) 555-55-5555

Address (No., Street, City, State, Zip) 123 Pine Tree Ln. Long Beach, CA 90803 Phone Number: (XXX) XXX-XXXX

Referral/Service Type Requested

Specialist Consult/Tx/FU Care Surgical Procedure Requested LOS: _____

Inpatient Admission Inpatient Facility: _____

Major Diagnostic Procedure Outpatient Date/Time of Service: 6/5/09

Home Health Hospice Other: Interpreter Needed

DME (refer to PA list) Comments: _____

Requesting Provider Information **Referring To Provider Information**

Requesting provider name (last, first) Dr. Lee Smith Referring to provider name (physician, mg/ipa, facility, agency) ISI (Interpretive Services)

Address: (No., Street, City, State, Zip) 456 PCH, Long Beach CA 90803 Address: (No., Street, City, State, Zip) _____

Specialty PCP Specialty _____

Phone Number (XXX) XXX-XXXX _____ Phone Number () - _____

Fax number (xxx) xxx-xxxx _____ Fax number () - _____

Service Request Information

ICD-9 Code #/Description: 250.0 Code or Description: T1013: Sign language or oral interpretive srvc.

Clinical indications for request: (include pertinent past medical hx. treatment, physical findings, and attach all relevant medical records and test results, etc)

Spanish interpreter needed for patient for 6/5/09 @ 1:15 pm

Requesting Practitioner Signature: X. Smith Date: 5 / 25 / 09

MOLINA Use Only

Criteria/guidelines met: yes no Authorization Status: approved modified deferred denied

Comments: _____

UM representative signature: _____ Date: _____ Approved LOS: _____

MEDICAL DIRECTOR REVIEW

APPROVED COMMENTS: _____

MODIFIED

DENIED

MEDICAL DIRECTOR SIGNATURE: _____ Date: ____ / ____ / ____

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CLAIMS PAYMENT IS CONTINGENT ON MEMBER ELIGIBILITY FOR DATE(S) OF SERVICE